

GUIDELINES FOR PHYSICIAN REPORT

INSTRUCTIONS TO PETITIONER: Fill in the information below and give this document to the court-appointed physician immediately after the ORDER APPOINTING PHYSICIAN is signed. Be sure a written report from the physician is given to everyone listed in the ORDER APPOINTING A PHYSICIAN no later than 10 days before the scheduled hearing.

COURT CASE NUMBER: PB _____

NAME OF PHYSICIAN: _____

NAME OF PATIENT: _____
(This is the person whom the Petitioner says needs a guardian and/or conservator)

NAME OF PETITIONER: _____

PETITIONER'S TELEPHONE NUMBER: _____

DATE AND TIME OF COURT HEARING: _____

INSTRUCTIONS TO PHYSICIAN: A court case has been filed that asks the court to appoint a guardian and/or conservator for the person named above. Before the court grants such a petition, the court must decide if mental, physical, or other cause exists which necessitates a guardianship or conservatorship. Therefore, the court needs to know what you, as the physician for the person, think about the person's health, whether the person needs inpatient mental health treatment, and whether the person's driving privileges should be suspended. The court's goal is to do all that is possible to help the person about whom this case is pending to live as fully as his or her mental or physical impairments allow.

The court realizes that your time is valuable, and has developed the following questions to make it easier for you to prepare your report. If you want to use some other format to submit your report, please feel free to do that too, so long as you provide the same type of information the court needs.

If the Petitioner is seeking the authority to consent to inpatient mental health treatment, this report must be signed by a licensed psychiatrist or psychologist.

After you complete the report, give the original report to the Petitioner and he or she will see to it that necessary copies are properly distributed. Please do not file your report with the Clerk of the Court. PLEASE DATE AND SIGN YOUR REPORT. THANK YOU FOR YOUR TIME AND ASSISTANCE.

QUESTIONS FOR PHYSICIAN TO ANSWER:

1. What is the date you last saw your patient _____
2. How long have you been his or her physician? _____
3. Why were you asked to do this evaluation?
 - ☐ You have been the person's physician for many years
 - ☐ You were asked to do so by the family
 - ☐ An attorney selected you
 - ☐ Your office is close to the person's residence
 - ☐ You are the doctor for the person's nursing home

☐ Other (please explain)

4. What is your area of specialty? _____
Are you Board Certified in this area? ☐ Yes ☐ No
In any other area? _____

5. Does the person appear to be having difficulty in any of the following areas?

- ☐ Mental disorder
☐ Physical illness
☐ Chronic intoxication or drug use
☐ Cognitive abilities
☐ Anything else

6. If the person is having difficulty, please specify the nature of the illness, disorder, etc. (include the person's diagnosis) _____

7. Has the person been treated or hospitalized before for this difficulty? ☐ Yes ☐ No
If yes, when and where? _____

8. Is the person able to do the following things? If the person is able, please check each applicable box.

- ☐ Pay his or her bills
☐ Obtain food
☐ Provide adequate housing
☐ Perform daily self-help skills
☐ Live alone
☐ Take medication appropriately
☐ Drive a motor vehicle
☐ Make appropriate judgments that will protect him or her personally, physically, or financially

If you believe the person is still able to drive a motor vehicle, but is in need of the assistance of a guardian, please explain why the person should be allowed to keep driving:

9. If the person is currently on medication, please list them.

10. Do you believe that the medication is affecting the person's ability to respond coherently? ☐ Yes ☐ No

11. Do you believe that the medication is affecting the person's ability to ambulate? ☐ Yes ☐ No

12. Do you believe that a "medication holiday," if possible, would help you better evaluate this person?
☐ Yes ☐ No
13. Do you believe that any changes made in the type or amount of drugs the person is receiving would noticeably affect his or her mental or physical abilities? ☐ Yes ☐ No
14. Do you believe that any further medical evaluation or treatment would benefit the person? ☐ Yes ☐ No
If so, please give your recommendation:

15. Do you think the person would benefit from other types of therapy such as counseling? Describe.

16. Where do you think the person should live today?

- ☐ At home with a companion
☐ At home with a nurse
☐ In a group home
☐ In a boarding home
☐ In a supervisory care facility
☐ In a nursing home
☐ In a hospital
☐ In a level one behavioral health facility for inpatient mental health treatment. Explain.
☐ Other -- please explain

17. Do you believe that the person's condition could improve within 6 months to a year? ☐ Yes ☐ No
18. Do you believe there is any reason for the court to review this matter again within 6 months to a year?
☐ Yes ☐ No
19. Please make any additional comments or suggestions you think would be helpful to the court in making this decision.

Mental Health Treatment Issues (This section must be completed if the petitioner is requesting authority to consent to inpatient mental health treatment.)

1. Is it the opinion of the undersigned that the patient is incapacitated as a result of a mental disorder?
☐ Yes ☐ No
2. What is the mental disorder? _____
3. Is it the opinion of the undersigned that the patient is currently in need of inpatient mental health care and treatment? ☐ Yes ☐ No (For the purpose of this question, the term "currently" means, based upon the medical professional's experience and training, and to a degree of medical probability, that the patient does now or will within a reasonably imminent and immediate time require inpatient mental health treatment.)

4. In the event that the answer to #3 is "Yes", please explain the need for, and the anticipated onset and duration of the inpatient treatment: _____

5. What kind of treatment is the patient currently receiving for this disorder? _____

6. Give a comprehensive assessment of any functional impairments of the patient. _____

7. How and to what extent do these impairments affect the patient's ability to receive or evaluate information needed in making or communicating personal and financial decisions? _____

8. What task of daily living is the patient capable of performing without direction or with minimal direction? _____

9. What is the most appropriate rehabilitation plan or care plan for the patient? _____

10. What would be the least restrictive living arrangement reasonably available for the patient? _____

11. Is there any reason why this patient should not personally appear in court? ☐ Yes ☐ No If "yes", please explain: _____

12. Please make any additional comments or suggestions you feel would be valuable to the court: _____

DATE REPORT PREPARED: _____

SIGNATURE OF PHYSICIAN: _____

PRINTED NAME OF PHYSICIAN: _____